Coventry Health Care of Georgia, Inc.: Premier Plus $25/$50 $1500/80%/60% NPOSGA

Coverage Period : 08/01/2013 - 07/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Emp. Only, Emp./Family **| Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.chcga.com or by calling 1-800-395-2545.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	In network: $1,500 person $4,500 family Excludes co-pays and co-insurance Out of network: $1,500 person $4,500 family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	In network: Yes. $3,000 person $9,000 family Out of network: Yes. $3,000 person $9,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out-of-pocket limit**?	Premiums, balance-billed charges, co-pays, deductibles, and some co-insurance	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes For a list of in-network providers, see www.chcga.com or call 1-800-395-2545.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance payment** of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In network Provider	Out of network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	Deductible + 40% co-insurance	----------none----------
	Specialist visit	$50 co-pay/visit	Deductible + 40% co-insurance	----------none----------
	Other practitioner office visit	$25 co-pay/visit	Deductible + 40% co-insurance	----------none----------
	Preventive care/ Screening/Immunization	$0 co-pay/visit	Deductible + 40% co-insurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$25 co-pay/visit x-ray $25 co-pay/visit lab	Deductible + 40% co-ins. x-ray and lab	----------none----------
	Imaging (CT/PET scans, MRIs)	Deductible + 20% co-ins.	Deductible + 40% co-ins.	Preauthorization is required or may not be covered.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chcga.com.	Generic drugs	$3 co-pay/fill or $15 co-pay/fill mail order: $6 co-pay/fill or $30 co-pay/fill	Not Covered	30 day supply, mail order is 90 day supply. Preauthorization may be required or not covered.
	Preferred brand drugs	$35 co-pay/fill mail order $87.50 co-pay/fill	Not Covered	30 day supply, mail order is 90 day supply. Preauthorization may be required or not covered.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In network Provider	Out of network Provider	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chcga.com.	Non-preferred brand drugs	$65 co-pay/fill mail order: $195 co-pay/fill	Not Covered	30 day supply, mail order is 90 day supply. Preauthorization may be required or not covered.
	Specialty drugs	10% co-insurance	Not Covered	$2,500annual out of pocket max. . Preauthorization may be required or not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% co-insurance	Deductible + 40% co-insurance	Preauthorization is required or may not be covered.
	Physician/surgeon fees	Deductible + 20% co-insurance	Deductible + 40% co-insurance	Preauthorization is required or may not be covered.
If you need immediate medical attention	Emergency room services	$200 co-pay/visit	$200 co-pay/visit	Must meet emergency criteria.
	Emergency medical transportation	$200 co-pay/trip	$200 co-pay/trip	----------none----------
	Urgent care	$75 co-pay/visit	$75 co-pay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% co-insurance	Deductible + 40% co-ins.	Preauthorization is required or may not be covered.
	Physician/surgeon fee	Deductible + 20% co-insurance	Deductible + 40% co-ins.	Preauthorization is required or may not be covered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 co-pay/visit	Deductible + 40% co-ins.	----------none----------
	Mental/Behavioral health inpatient services	Deductible + 20% co-insurance	Deductible + 40% co-ins.	Preauthorization is required or may not be covered.
	Substance use disorder outpatient services	$50 co-pay/visit	Deductible + 40% co-ins.	Preauthorization is required or may not be covered.
	Substance use disorder inpatient services	Deductible + 20% co-insurance	Deductible + 40% co-ins.	Preauthorization is required or may not be covered.
If you are pregnant	Prenatal and postnatal care	$50 co-pay/pregnancy	Deductible + 40% co-ins.	----------none----------
	Delivery and all inpatient services	Deductible + 20% co-insurance	Deductible + 40% co-ins.	----------none----------

Common Medical Event	Services You May Need	Your cost if you use a In network Provider	Your cost if you use a Out of network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible + 20% co-insurance	Deductible + 40% co-ins.	Preauthorization is required or may not be covered. Limited to 60 visits per benefit year.
	Rehabilitation services	Inpatient Deductible + 20% co-insurance Outpatient $50 co-pay/visit	Inpatient Deductible + 40% co-ins. Outpatient Deductible + 40% co-ins.	Limited. to 30 outpatient visits/yr.
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care (facility)	Deductible + 20% co-insurance	Deductible + 40% co-ins.	Limited to 60 days/yr..
	Durable medical equipment (including supplies)	50% co-insurance	50% co-insurance	Preauthorization is required or not covered. Co-ins. does not apply to out of pocket maximum.
	Hospice Services	Deductible + 20% co-insurance	Deductible + 40% co-ins.	Preauthorization is required or not covered.
If your child needs dental or eye care	Eye exam	$15 co-pay	Not covered	Limited to 1 exam in 12 months. Excludes hardware.
	Glasses	Not covered	Not covered	Excluded service
	Dental check-up	Not Covered	Not Covered	Excluded service

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Acupuncture
- Bariatric Surgery
- Child/Dental Check-up
- Child/Glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Habilitation services
- Hearing Aids
- Long-Term Care
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Infertility Treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-395-2545. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Appeals and Grievances:

For group health coverage subject to ERISA, you may contact 1-800-395-2545. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or your state department of insurance at Georgia Department of Insurance Seventh Floor, West Tower Floyd Building Martin Luther King, Jr. Drive Atlanta, GA 30333 404-656-2056.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-395-2545 or your state department of insurance at Georgia Department of Insurance Seventh Floor, West Tower Floyd Building Martin Luther King, Jr. Drive Atlanta, GA 30333 404-656-2056.

Additionally, a consumer assistance program can help you file your appeal. Contact Georgia Office of Insurance and Safety Fire Commissioner Consumer Services Division 2 Martin Luther King, Jr. Drive West Tower, Suite 716 Atlanta, Georgia 30334 (800) 656-2298 http://www.oci.ga.gov/ConsumerService/Home.aspx

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-395-2545.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-395-2545.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-395-2545.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-395-2545.

——————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*——————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection you might get from different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,140
- **You pay:** $2,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital Charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

You pay:

Deductibles	$1,500
Co-pays	$100
Coinsurance	$600
Limits or exclusions	$200
Total	**$2,400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,790
- **You pay:** $1,610

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccine, other preventive	$100
Total	**$5,400**

You pay:

Deductibles	$0
Co-pays	$1,500
Coinsurance	$30
Limits or exclusions	$80
Total	**$1,610**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium** , the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance** . You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.